CY 2021 Medicare Physician Fee Schedule Final Rule

CMS released the calendar year (CY) 2021 Medicare Physician Fee Schedule final rule on Tuesday, December 1, 2020. This rule finalized several items relevant to therapy services, including payment updates for services paid via the Physician Fee Schedule (PFS), telehealth and communication technology-based services policy updates, changes to maintenance therapy regulations, and updates to the Merit-based Incentive Payment System (MIPS).

CMS also included two small interim final rules with comment period (IFC) in this final rule to establish coding and payment for services related to the COVID-19 public health emergency (PHE). This information is summarized at the end of this document.

Therapy Threshold (KX modifier application) – Information not found in the final rule

The therapy threshold amount is typically identified in the Fee Schedule final rule. However, this year's final rule did not contain (or even mention) the therapy threshold for CY 2021. Instead, CMS published transmittal CR12014CP (released 12/3/2020) which indicates that **the CY 2021 threshold amount is $2110 for physical therapy (PT) and speech-language pathology (SLP) combined and $2110 for occupational therapy (OT)**. The KX modifier should be appended to Part B therapy services over the threshold amount as the therapist's attestation that the services are medically necessary. The medical review threshold remains at $3000 (and will continue as such through 2028).

Payment Updates

CMS finalized a 10.20% decrease in the fee schedule conversion factor for 2021 – a budget neutrality adjustment of -10.20% with a statutory increase of 0.0% (because there are no adjustments to the fee schedule by law through 2025), resulting in a conversion factor of 32.4085 (vs. 36.0896 for CY 2020).

As a result of this significant decrease in the conversion factor, physical and occupational therapy (and speech therapy) services will see an overall 9% reduction in reimbursement in services paid via the physician fee schedule (PFS) in 2021. In last year's final rule, CMS finalized changes to increase reimbursement for the outpatient/office physician evaluation and management (E/M) CPT codes beginning in CY 2021. As a result of the requirement for fee schedule updates to remain budget neutral, many specialties face cuts in 2021 to offset the increase in payment for the physician E/M codes (hence, the -10.20% budget neutrality adjustment to the conversion factor). Physician specialties that bill office/OP E/M codes will generally see increases in payment – some are very significant.

CMS emphasizes that "estimated impact" percentages noted in Table 106 of the final rule are based on aggregate estimates of allowed charges (including coinsurance and deductibles) summed across all services and are therefore "averages," and do not represent what will actually happen to a particular service furnished by a single provider.

Excerpt from TABLE 106: CY 2021 PFS Estimated Impact on Total Allowed Charges by Specialty

Specialty	Allowed Charges (million)	Combined Impact
Allergy/Immunology	$246	9%
Audiologist	$74	-6%
Cardiac Surgery	$264	-8%
Chiropractor	$759	-10%
Clinical Social Worker	$851	1%

Emergency Medicine	$3,065	-6%
Endocrinology	$506	16%
Family Practice	$5,982	13%
Geriatrics	$190	3%
Independent Laboratory	$639	-5%
Internal Medicine	$10,654	4%
Nurse Anesthetist / Anes Asst	$1,316	-10%
Nurse Practitioner	$5,069	7%
Ophthalmology	$5,328	-6%
Orthopedic Surgery	$3,796	-4%
Physical Medicine	$1,157	-3%
Physical / Occupational Therapy	$4,946	-9%
Radiology	$5,253	-10%
Rheumatology	$546	15%

Therapy Evaluations

With the revaluing of the physician E/M code set, CMS identified other services paid under the PFS that are similar to the office/outpatient E/M code set and include the work associated with assessment and management, like the E/M codes do. Therapy evaluations were identified as one of these types of services. As such, **CMS adjusted (i.e., increased) the work relative value units (RVUs) for therapy evaluations** and calculated the adjustment based on a "volume-weighted average" of the increases to the office/OP E/M work RVUs.

Note: While the increase to the therapy evaluation codes is a positive adjustment, it does not counterbalance the significant decrease to every other PT, OT, and SLP CPT code as a result of the decrease in the conversion factor.

Excerpt from TABLE 25: Current and Final Work RVUs for Therapy [Evaluation Codes]

HCPCS Code	Description	Current Work RVU	Final 2021 Work RVU
97161	PT Evaluation, low complexity	1.2	1.54
97162	PT Evaluation, moderate comp	1.2	1.54
97163	PT Evaluation, high complexity	1.2	1.54
97164	PT Re-evaluation	0.75	0.96
97165	OT Evaluation, low complexity	1.2	1.54
97166	OT Evaluation, moderate comp	1.2	1.54
97167	OT Evaluation, high complexity	1.2	1.54
97168	OT Re-evaluation	0.75	0.96
92521	Eval of speech fluency	1.75	2.24
92522	Eval of speech sound production	1.5	1.92
92523	Eval of speech sound prod w/ eval of language comp & exp	3	3.84
92524	Behavioral & qual analysis of voice & resonance	1.5	1.92

Telehealth and Communication Technology-Based Services (CTBS)

During the COVID-19 PHE, CMS added a number of services to the Medicare telehealth services list to facilitate beneficiary access to necessary medical services. In this rule, CMS finalized the decision to add some of these services to the telehealth list permanently, to create a new option for adding services to the list on a temporary basis ("Category 3"), and to not retain some services on the telehealth list after the PHE ends. **Therapy CPT codes are being added to the Medicare telehealth services list on a "Category 3" basis, meaning the codes will remain on the list through the end of the calendar year in which the COVID-19 PHE ends** (i.e., if the PHE ends in 2021, the codes will remain on the list until 12/31/2021).

CMS again clarified that changes to the approved/eligible provider list for telehealth services – that is, adding PTs, OTs, and SLPs as approved providers of telehealth on a permanent basis – requires a change to statute (Congressional action). Therefore, **the addition of therapy-specific CPT codes to the Medicare telehealth services list on a Category 3 basis makes these codes available for *other* eligible providers (physicians, nurse practitioners, etc.) to provide via telehealth, but *not* for therapists once the PHE ends**, unless the services are provided incident-to a physician. CMS states that because these therapy services are now included on the telehealth list, they can be furnished by a therapist and billed by a physician or practitioner who can furnish and bill for telehealth services provided that "all of the incident to requirements are met."

The PT/OT/SLP CPT codes being added to the Medicare Telehealth List on a Category 3 basis are:

97161-97168	97110	97112	97116
97535	97750	97755	97760
97761	92521-92524	92507	

Note: CPT codes 97530, 97542, 97150, and 92508 are not included on this list, although they are on the approved telehealth list through the end of the PHE.

Information from TABLE 16: Summary of CY 2021 Services Added to the Medicare Telehealth Services List

Type of Service	Specific Services and CPT Codes
1. Services CMS finalized for permanent addition as Medicare Telehealth Services	▪ Group psychotherapy (CPT 90853) ▪ Domiciliary, rest home, or custodial care services, established patients (CPT 99334-99335) ▪ Home visits, established patient (CPT 99347-99348) ▪ Cognitive assessment & care planning services (CPT 99483) ▪ Visit complexity inherent to certain office/OP E/M (HCPCS G2211) ▪ Prolonged services (HCPCS G2212) ▪ Psychological and neuropsychological testing (CPT 96121)
2. Services finalized as Category 3, temporary additions to the Medicare telehealth services list	▪ Domiciliary, rest home, or custodial care services, established patients (CPT 99336-99337) ▪ Home visits, established patient (CPT 99349-99350) ▪ Emergency dept visits, levels 1-3 (CPT 99281-99283) ▪ Nursing facilities discharge day management (CPT 99315-99316) ▪ Psychological and neuropsychological testing (CPT 96130-96133) ▪ Psychological and neuropsychological testing (CPT 96136-96139)

	▪ **Therapy services, physical and occupational therapy (CPT 97161-97168, 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)** ▪ Hospital discharge day management (CPT 99238-99239) ▪ Inpatient neonatal and pediatric critical care, initial and subsequent (CPT 99477-99480) ▪ Continuing neonatal intensive care services (CPT 99478-99480) ▪ Critical care services (CPT 99291-99292) ▪ End-stage renal disease monthly capitation payment codes (CPT 90952, 90953, 90956, 90959, 90962) ▪ Subsequent observation and observation discharge day management (CPT 99217, 99224-99226)
3. Services not being added to the Medicare telehealth list, either permanently or temporarily	▪ Initial nursing facility visits, all levels (CPT 99304-99306) ▪ Initial hospital care (CPT 99221-99223) ▪ Radiating treatment management services (CPT 77427) ▪ Domiciliary, rest home, or custodial care services, new (CPT 9932-99328) ▪ Home visits, new patient, all levels (CPT 99341-99345) ▪ Inpatient neonatal and pediatric critical care, initial (CPT 99468, 99471, 99475, 99477) ▪ Initial observation and observation discharge day mgmt. (CPT 99218-99220, 99234-99236) ▪ Medical nutrition therapy (HCPCS G0271)

CMS finalized the policy established during the PHE that allows PTs, OTs, and SLPs to furnish and bill HCPCS G2061, G2062, and G2063 (E-visits) on a permanent basis. CMS also finalized the decision to allow billing of other communication technology-based services (CTBS) by nonphysician practitioners who cannot independently bill E/M services (e.g., therapists) by **creating two new HCPCS G codes to represent virtual check-ins and remote assessment of recorded video/images.** These codes should be used instead of G2010 and G2012 for these practitioners and will be valued the same:

> **G2250** – Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation and follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment.
>
> **G2251** – Brief communication technology-based service, e.g., virtual check-in, by a qualified health professional who cannot report E/M services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

CMS has designated G2061, G2062, G2063, G2250, and G2251 as "sometimes therapy services," such that when billed by ***a private practice PT, OT, or SLP***, the codes require the corresponding GP, GO, or GN modifier.

Note: These services are available to therapists in private practice to render and bill permanently effective 1/1/2021. However, **therapists who bill on institutional claims (UB-04) will not be able to provide and bill Medicare Part B for these services after the COVID-19 PHE ends**.

CMS states they will not extend coverage of the telephone assessment codes (98966-98968) beyond the PHE.

CMS again clarifies in the final rule that if audio/video technology is used in furnishing a service when the beneficiary and the practitioner are in the same institutional or office setting, the practitioner should bill as if the service was furnished in person and the service would not be subject to any of the telehealth requirements.

Direct Supervision

Background: Direct supervision means the physician or practitioner must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. Direct supervision does not require the physician/practitioner to be present in the room when the service or procedure is performed. Direct supervision as defined here applies to therapists in private practice as PTAs and OTAs require direct supervision of the PT or OT in the private practice setting.

For the duration of the COVID-19 PHE, CMS adopted an interim final policy revising this definition of direct supervision to include the "virtual presence" of the supervising physician/practitioner using "interactive audio/video real-time communications technology." In this rule, **CMS finalizes their decision to extend this virtual direct supervision policy until the later of the end of the calendar year in which the PHE ends or 12/31/2021**.

CMS also clarifies that the requirement for direct supervision could be met by the supervising physician or practitioner (or therapist) being immediately able to engage via audio/video technology, and does not require real-time presence or observation of the service via interactive audio/video technology throughout the performance of the procedure.

Remote Physiologic Monitoring (RPM)

Remote physiologic monitoring (RPM) involves the collection and analysis of patient physiologic data used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. CMS states they have received many questions about several of the CPT codes describing RPM services and about CMS' RPM policies. In the final rule, CMS again clarifies payment policies related to RPM, including, and most relevant to therapists, **that the CPT codes for RPM services are E/M codes and therefore may only be billed by physicians and practitioners who are able to bill these codes – i.e., not PTs, OTs, or SLPs.**

Maintenance Therapy

CMS finalized their decision to make permanent the Part B policy for maintenance therapy services that was put in place with the second COVID-19 PHE Interim Final Rule with comment period (IFC) published 5/1/2020. Under this policy, **the PT or OT who establishes the maintenance program may delegate the performance of maintenance therapy services to a PTA or OTA, as clinically appropriate**. This policy is effective 1/1/2021, and aligns Medicare Part B policy with current policy under Part A in the skilled nursing facility (SNF) and home health (HH) settings.

Medical Record Documentation

CMS clarified that a broad policy principle regarding clinicians being able to review and verify documentation added to the medical record for their services by other members of the medical team, including students, also applies to therapists. Therapists who are authorized to furnish and bill for their professional services may review and verify (sign and date) documentation in the medical record for services they bill rather than re-document notes made by therapy students or other members of the medical team. This means students can

document in the medical record, as long as it is reviewed and verified (i.e., signed and dated) by the billing therapist.

Merit-based Incentive Payment System (MIPS)

PT, OT, and SLP eligibility for participation in MIPS continues into the 2021 performance year (i.e., the 2023 payment year). MIPS remains available for therapists in private practice only (i.e., those who bill on professional claims).

MIPS Value Pathways

CMS will delay implementation of the MIPS Value Pathways (MVPs) until at least performance year 2022. The MVP framework will connect measures and activities across the four MIPS categories, incorporate a set of administrative claims-based quality measures that focus on population health, provide data and feedback to clinicians, and enhance the information provided to patients. CMS believes this MVP framework will reduce the complexity of the program and the burden to participate and will balance flexibility with standardization to allow for better comparisons across providers/clinicians.

Quality Category

CMS did not make any changes to the minimum number of quality measures (six) or to the data completeness threshold, which will remain at ≥ 70% of all eligible patients *regardless of payer*, if using a reporting method other than via the claim (such as a Qualified Registry or Qualified Clinical Data Registry (QCDR)). If utilizing Medicare Part B claims reporting (again, available to small practices of ≤ 15 clinicians only in 2021), data must be submitted on ≥ 70% of eligible Medicare Part B patients. CMS will also continue quality category scoring and bonus policies, including improvement scoring.

CMS finalized the addition of quality measures 286 and 288 and the removal of measure 282 to the PT/OT specialty set as proposed.

The PT/OT Specialty Set (Appendix B.32):

Measure	Description	Measure	Description
126	Diabetic Foot/Ankle Care, Peripheral Neuropathy – Neurological Evaluation	217	Functional Status Change for Patient w/ Knee Impairments using FOTO Patient Reported Outcome Measurement
127	Diabetic Foot/Ankle Care, Ulcer Prevention – Eval of Footwear	218	…Hip Impairments using FOTO PROM
128	BMI Screening and Follow-up	219	…Foot/Ankle Impairments using FOTO PROM
130	Documentation of Current Meds	220	…Lumbar Impairments using FOTO PROM
134	Screening for Depression & Follow-up	221	…Shoulder Impairments using FOTO PROM
154	Falls: Risk Assessment	222	… Elbow/Wrist/Hand Impairments using FOTO PROM
155	Falls: Plan of Care	478	…Neck Impairments using FOTO PROM
181	Elder Maltreatment Screen & Follow-up Plan	281	Dementia: Cognitive Assessment (eCQM)
182	Functional Outcome Assessment	283	Dementia Associated Behavioral & Psychological Symptoms Screening & Management
226	Tobacco Use: Screening & Cessation Intervention	286	Dementia Safety Concern Screening & Follow-up

318	Falls: Screening for Future Fall Risk (eCQM)	288	Dementia: Education & Support of Caregivers for Patients with Dementia

The Physical Medicine Specialty Set measures applicable to PT/OT (Appendix B.31):

Measure	Description	Measure	Description
128	BMI Screening and Follow-up	182	Functional Outcome Assessment
130	Documentation of Current Meds	226	Tobacco Use: Screening and Cessation Intervention
154	Falls: Risk Assessment	402	Tobacco Use and Help with Quitting Among Adolescents
155	Falls: Plan of Care	431	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

CMS also finalized the addition of measure 134 to the SLP specialty set as proposed.

The SLP Specialty Set (Table B.39):

Measure	Description	Measure	Description
130	Documentation of Current Meds	182	Functional Outcome Assessment
134	Screening for Depression & Follow-up	226	Tobacco Use: Screening and Cessation Intervention
181	Elder Maltreatment Screen & Follow-up Plan		

CMS states that after reviewing MIPS data submitted during performance year 2019, the data is sufficient to determine historical benchmarks. Therefore, CMS finalized the decision to use historical benchmarks for performance year 2021, instead of the proposed performance period benchmarks.

For the 2023 payment year, scoring remains essentially the same as for the 2022 payment year. "Case minimum" requirements for all quality measures in 2021 is 20 cases, which is unchanged from 2019 and 2020.

TABLE 49: Quality Performance Category: Scoring Policies for the CY 2021 MIPS Performance Period

Measure Type	Description	Scoring Rules
Class 1	Measures submitted or calculated that meet all of the following criteria: 1) Has a benchmark; 2) Meets case minimum; and 3) Meets the data completeness standard (generally, 70% for 2021)	3 to 10 measure achievement points based on performance compared to the benchmark
Class 2	Measures that are submitted and meet data completeness, but do not have either of the following: 1) A benchmark; and 2) Meets case minimum	3 measure achievement points
Class 3	Measures that are submitted, but do not meet data completeness threshold, even if they have a measure benchmark and/or meet the case minimum	Beginning with the 2020 performance period: MIPS eligible clinicians other than small practices will receive zero points; small practices – 3 points

Improvement Activities Category

In addition to the Quality category, MIPS-eligible PTs, OTs, and SLPs will continue to report Improvement Activities in 2021. Eligible clinicians or groups must attest to completing improvement activities for at least a continuous 90-day period during the 12-month performance period.

Activities continue to be categorized as "high-weighted" or "medium-weighted" based on the amount of time and resources it takes to implement and complete the activity. Scoring for Improvement Activities remains unchanged.

MIPS Category Weighting

CMS states it will continue reweighting the Cost and Promoting Interoperability categories for PTs, OTs, and SLPs to the Quality category in 2021. For the 2023 payment year (the 2021 performance year), CMS finalized weighting of the four MIPS categories, along with reweighting cost and promoting interoperability for therapists, as follows:

MIPS Category	2023 Weight	2023 Weight for PT/OT/SLP
Quality	40%	85%
Cost	20%	0%
Improvement Activities	15%	15%
Promoting Interoperability	25%	0%

MIPS Scoring

In last year's final rule, CMS finalized a performance threshold of 60 points for 2023 payment year (the 2021 performance year). In the 2021 proposed rule, CMS discussed lowering the performance threshold to 50 points for the 2023 payment year, in anticipation of fewer participating clinicians and challenges with data completeness during 2019 due to the COVID-19 PHE. However, in the final rule, CMS states data analysis for the 2019 calendar year indicated that a threshold of 60 points was appropriate and achievable. (The mean final score for 2019 was 79.8; and the median, 85.27). Therefore, **CMS finalized a performance threshold of 60 points for performance year 2021**. This means clinicians and groups participating in MIPS in 2021 will need to achieve at least 60 total points to not receive a penalty during the 2023 payment year. The "additional performance threshold" – or exceptional performance benchmark – will remain 85 points as finalized last year.

The maximum payment adjustment for payment year 2023 is +/- 9%. The MIPS program remains budget neutral, however, such that incentives are paid based on penalties incurred. Incentive percentages are based on a "scaling factor" that increases as the number (and amount) of penalties increase. More MIPS eligible clinicians with scores above the performance threshold means the scaling factor decreases; more clinicians below the performance threshold means the scaling factor increases. As the scaling factor increases, the incentive percentage increases. For example, if the scaling factor is 0.395, a clinician who scores 100 points in MIPS would receive a 3.95% adjustment, along with the exceptional performance bonus (which is paid from additional dollars).

TABLE 57: Illustration of Points System and Associated Adjustments Comparison between Finalized 2022 MIPS Payment Year and the Finalized 2023 MIPS Payment Year

2022 MIPS Payment Year		Finalized 2023 MIPS Payment Year	
Final Score Points	MIPS Adjustment	Final Score Points	MIPS Adjustment
0.0-11.25	Negative 9%	0.0-15.0	Negative 9%
11.26-54.99	Negative adjustment greater than -9% and less than 0% on a sliding scale	15.01-59.99	Negative adjustment greater than -9% and less than 0% on a sliding scale
45.0	0% adjustment	60.0	0% adjustment
45.01-84.99	Positive adjustment greater than 0% on a sliding scale ranging from 0-9% for scores from 45.00-100.00. The sliding scale is multiplied by a scaling factor > 0 but not exceeding 3.0 to preserve budget neutrality.	60.01-84.99	Positive adjustment greater than 0% on a sliding scale ranging from 0-9% for scores from 60.00-100.00. The sliding scale is multiplied by a scaling factor > 0 but not exceeding 3.0 to preserve budget neutrality.
85.0-100	Positive adjustment > 0% on a sliding scale (as above); PLUS an additional MIPS payment adjustment for exceptional performance – starts at 0.5% and increases on a linear sliding scale ranging from 0.5-10% for scores from 85.00 to 100. This sliding scale is multiplied by a scaling factor not > 1.0 to proportionately distribute the available funds.	85.0-100	Positive adjustment > 0% on a sliding scale (as above); PLUS an additional MIPS payment adjustment for exceptional performance – starts at 0.5% and increases on a linear sliding scale ranging from 0.5-10% for scores from 85.00 to 100. This sliding scale is multiplied by a scaling factor not > 1.0 to proportionately distribute the available funds.

Qualified Registries and QCDRs (i.e., Third Party Intermediaries)

In last year's final rule, CMS finalized that Qualified Registries and QCDRs must be able to submit Quality, Improvement Activities, and Promoting Interoperability data, and Health IT vendors must be able to submit data for at least one category beginning in performance year 2021. Qualified Registries and QCDRs that only represent MIPS eligible clinicians that are eligible for reweighting under the promoting interoperability category (for example, physical therapists) are not required to report this category.

In this final rule, CMS also states that QCDRs and Qualified Registries must conduct annual data validation audits (changed terminology), and if one or more deficiencies or data errors are noted, the intermediary must conduct random audits. Both types of audits must comply with sampling methodology CMS outlines in the rule, must be conducted for each submitter type (individual clinician, group, virtual group, opt-in clinician/group, voluntary participation), must use clinical documentation provided by the clinicians the entity is submitting data for to validate the action or outcome, and the audits must be completed and all deficiencies corrected prior to submitting data to CMS.

For more information on MIPS in 2021, click **here**.

IFC for Coding and Payment of Virtual Check-in Services

Outside of the circumstances for the COVID-19 PHE, Medicare does not provide separate payment for a service that would be a substitute for an in-person visit but isn't considered "telehealth," meaning a service that is furnished using two-way audio technology (vs. audio/video technology). However, after reviewing many stakeholder comments, CMS states they recognize the need for continuing coding and payment for audio-only services outside of the PHE, not necessarily as a substitute for an in-person visit, but as a tool for determining whether an in-person visits is needed, particularly as beneficiaries may still be cautious about exposure risks, even after the PHE ends.

Therefore, for CY 2021, on an interim basis, CMS is establishing **HCPCS code G2252** (Brief communication technology-based service, e.g., **virtual check-in,** by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; **11-20 minutes** of medical discussion). (The current virtual check-in code, G2012, is for 5-10 minutes of medical discussion.) Virtual check-ins can be conducted using two-way audio/video technology OR audio-only technology, and therefore, this new code can be used for those "audio only" communications (telephone calls) that take longer than 10 minutes.

This policy makes this code available for physicians and other practitioners who can bill E/M services for the duration of CY 2021, even if the PHE ends prior to the end of the year.

Note*:* This code is not available to PTs, OTs, and SLPs – not during the PHE and not after. For the duration of the PHE, therapists can use the telephone assessment codes, 98966-98968, for patient-initiated audio-only communications. Once the PHE ends, coverage of these telephone assessment and management codes ceases.

IFC for Coding and Payment for Personal Protective Equipment (CPT 99072)

The AMA CPT Editorial Panel approved the creation of CPT code 99072 (Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease) in September, 2020. CMS received many comments from stakeholders urging Medicare coverage for this code.

In this rule, CMS states that after review of the information provided by stakeholders, they are **finalizing CPT 99072 as a bundled service on an interim basis**. CMS states they agree that there have been additional costs for providers during the PHE, but that payment for these "services" as described under CPT 99072 are always bundled (meaning, Medicare will not separately reimburse for this code).

CMS is finalizing, on an interim basis, increases to supply pricing, based on invoices submitted by commenters, for a few items of PPE, specifically, the per item charge for the N95 mask, surgical mask, surgical mask with face shield will be increased. However, current pricing for non-sterile gloves, nitrile gloves, patient gowns, and sterile surgical gowns will remain the same as current pricing.

For more information, access the **CMS's Final Rule Fact Sheet**.
And, access the **CY 2021 Final Rule**.